



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

Bose Ogbeifun
Trustcare Group Home Inc
Suite 604 West
15565 Northland Drive
Southfield, MI 48075

RE: License #: AS820284963
Investigation #: 2023A0901017
Puritan AFC

Dear Ms. Ogbeifun:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive, flowing style.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AS820284963
Investigation #:	2023A0901017
Complaint Receipt Date:	02/01/2023
Investigation Initiation Date:	02/03/2023
Report Due Date:	04/02/2023
Licensee Name:	Trustcare Group Home Inc
Licensee Address:	Suite 604 West 15565 Northland Drive Southfield, MI 48075
Licensee Telephone #:	(248) 569-1102
Administrator:	Bose Ogbeifun
Licensee Designee:	Bose Ogbeifun
Name of Facility:	Puritan AFC
Facility Address:	24691 Puritan Redford, MI 48239
Facility Telephone #:	(313) 535-0095
Original Issuance Date:	09/19/2006
License Status:	REGULAR
Effective Date:	04/10/2021
Expiration Date:	04/09/2023
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED
----------------------	--

II. ALLEGATION(S)

	Violation Established?
Resident A's back was burned while staff was braiding her hair.	Yes

III. METHODOLOGY

02/01/2023	Special Investigation Intake 2023A0901017
02/03/2023	Special Investigation Initiated - Telephone Complainant
02/03/2023	APS Referral Came from APS
02/03/2023	Referral - Recipient Rights
02/03/2023	Contact - Telephone call made Home Manager, Qiana Jackson
02/07/2023	Contact - Document Received Fax
02/07/2023	Contact - Telephone call made Home Manager, Qiana Jackson
02/07/2023	Contact - Telephone call made Staff, Ini Eton
02/09/2023	Contact - Telephone call made Case Manager
02/09/2023	Contact - Telephone call made Guardian

02/09/2023	Inspection Completed On-site Resident A
02/15/2023	Contact - Telephone call received Complainant
03/10/2023	Inspection Completed-BCAL Sub. Compliance
03/10/2023	Exit Conference Licensee Designee, Bose Ogbeifun

ALLEGATION:

Resident A's back was burned while staff was braiding her hair.

INVESTIGATION:

On 02/03/2023, I made a telephone call to the complainant and left a voice message.

On 02/07/2023, I made a telephone call to the home manager, Qiana Jackson. She stated she did not know about the incident until Resident A's mother called and asked her about it. Ms. Jackson contacted the home and was told that Resident A was treated at the hospital for the burn and an incident report was completed. The incident occurred in December 2022. Ms. Jackson did not have many details due to due to still gathering information. She stated she would forward me a copy of the incident report and paperwork from the hospital.

On 02/07/2023, I received a copy of the incident report and hospital discharge paperwork. It indicated that on 12/10/2022, while staff was assisting Resident A with her shower, it was discovered that she had a burn on her back. When asked what happened, Resident A stated it was an accident. Staff called 911 and Resident A was taken to Beaumont hospital in Farmington. Hospital paperwork confirmed that she was seen treated and discharged from Beaumont hospital on 12/10/2022. She was diagnosed with having a superficial partial thickness burn of scapular region. She was prescribed Bacitracin ointment and Ibuprofen.

On 02/07/2023, I made a telephone call to Ms. Jackson. I inquired about whether or not there was another incident report, because the one I received did not give details regarding how she received the burn and the staff involved. She stated that was the only incident report completed and that the staff involved was Ini Eton. Ms. Jackson explained that she did an internal investigation and discovered Ini was braiding Resident A's hair. As she was dipping the braids in hot water, Resident A

unexpectedly got up causing the hot wet braids to fall against her back. Ini, at the time did not know Resident A was burned, which is why she did not do an incident report. It was brought to Ini's attention a couple days later when staff, Rosaline Osagie, discovered it.

On 02/07/2023, I made a telephone call to staff, Ini Eton. She stated she was braiding Resident A's hair. She did not remember the exact date. The style she was doing required her to dip the braids in hot water. As she was dipping the braids, Resident A stood up. Ini explained that the guardian of another resident came in the house. She described Resident A as being very busy and nosy. As soon as she heard someone enter, she jumped up to see who it was. This caused the braids to slide out the water and touch her back. Ini stated she had a towel to wrap the braids in once she was done dipping them, but everything happened so fast and unexpected that she did not have a chance to grab it before Resident A got up. Afterwards, she asked Resident A was she ok, which she reported she was fine. She checked her back and there was not a burn at that time and Resident A was not complaining or seemed to be in pain.

On 02/09/2023, I made a telephone call to Resident A's case manager, Dempster Yallah, from Lincoln Behavioral Services. He stated he was not aware of the incident and further reported not having any other issues with the home.

On 02/09/2023, I made a telephone call to Resident A's guardian Portia, Lyle from Guardian Family Care Helpers. She stated she did not know about the incident until made aware of it by Resident A's mother and they followed up with a call to the home.

On 02/09/2023, I conducted an onsite inspection at the facility. I attempted to interview Resident A but she refused to talk to me or show me her back. She kept stating it was an accident and that she moved when she was not supposed to. The more questions I asked the more agitated she became, and she thought I was with the police.

On 02/15/2023, I received a telephone call from the complainant. She stated she noticed the burn on 01/27/2023 while assisting Resident A with a shower. She said the incident happened sometime in December 2022.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information obtained during this investigation, Resident A's safety and protection was not attended to. Considering the hairstyle involved the use of hot water, safety measures should have been in place to minimize risk to Resident A. In addition to this, Ini described Resident A as being busy. Therefore, she was aware of her behavior and extra precautions should have been taken to safeguard her.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend the status of the license remains unchanged.



Regina Buchanan
Licensing Consultant

03/10/2023
Date

Approved By:



Ardra Hunter
Area Manager

03/13/2023
Date